



Washington State
Department
of Social
& Health
Services

Spring 2007 Forum

May 15, 2007

Agenda For Today

- 1. Background and brief overview of STI projects
- 2. Involuntary Treatment Act Update
- 3. Benefits Package Update
- 4. Housing Action Plan Update
- 5. Wrap Up



Background

Challenges Facing the 2006 Legislature

- Decreasing community psychiatric inpatient capacity
- State hospital waiting lists
- Court rulings in September 2005
 - No wait for transfer of 90/180 ITA patients
 - > Failure to follow proper procedures for assessing "liquidated damages"
- Variable inpatient utilization and lengths of stay
 - Long lengths of stay in Washington's state hospitals
 - Significant disparities in lengths of stay when comparing state hospitals
 - Significant disparities between RSNs in per capita inpatient utilization



Background (cont'd)

Legislative Approach

- Clarified roles of State & RSNs related to community and state hospital care
- Time limited investment in State Hospital capacity to deal with inpatient access issues
- Investment in enhanced community resources to reduce reliance on state hospitals
 - PACT
 - Funding for PALS Residents
- By January 2008, requires RSNs to pay for individuals at PALS
- Long term planning



Key Provisions (cont'd)

Community Based Care (cont'd)

- Funding for PACT & other Expanded Community Services
 - Development funds FY 07
 - Operational Funds FY 08
 - Contract for Training & TA- WIMIRT
- Long Term Planning Consultant Contracts
 - Benefits Package/ Rates- TRI West
 - Involuntary Treatment Act- TRI West
 - Mental Health Housing Plan- Common Ground
 - External Utilization Review- University of Washington- Harborview



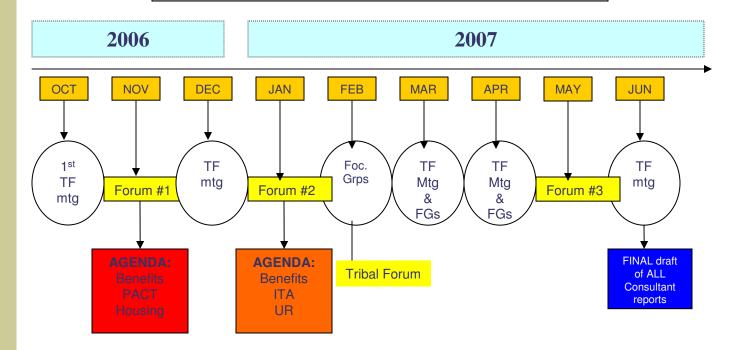
STI Implementation

Process

- Consultants For Each Project Initiative
- Standing Representative Task Force
 - > 35-40 members from variety of interested parties
 - Monthly meetings beginning in Oct 06
 - Consumer, family, and advocate representatives
- Community Forums- approximately 150 people
 - November 06, January 07, and May 07
- Tribal Roundtable and focus groups- Feb May 2007
- Focus Groups- by consultants as needed
- STI Web Site

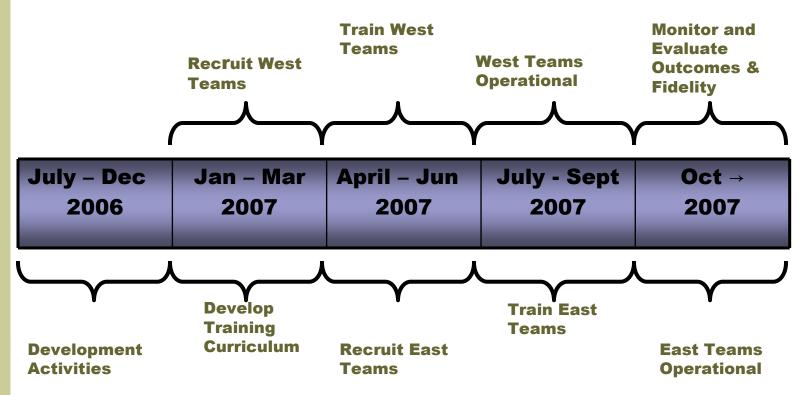


STI Task Force & Community Forum Timeline





PACT Implementation Timeline





Washington State
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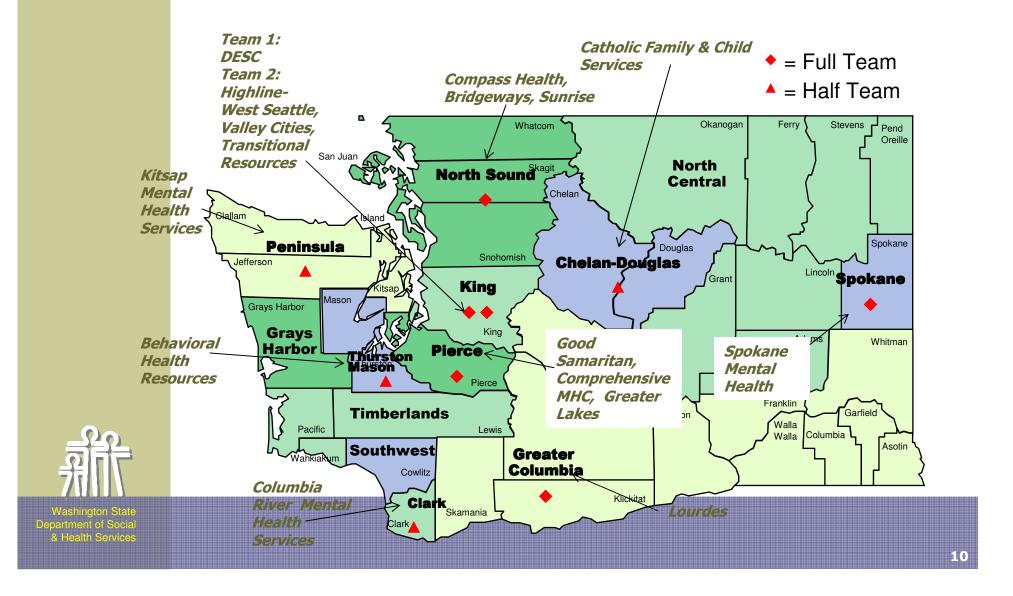
PACT Implementation

Status

- WA-PACT Standards are final- increased focus on consumer self direction and recovery focus
- WA-PACT Policy & Procedure Guidelines are final and have been distributed
- MHD contracts with RSNs
- RSN selection of PACT providers
- TA & Training for RSNs, Providers, Western State Hospital, and consumers
- Western PACT providers in process of staff recruitment for each team
- MHD PACT TA Web Site



WA-PACT RSNs & Selected Providers



PACT Implementation

What's Next

- Continued TA & Training for both Western and Eastern RSNs and providers
 - Team Leader Webcast Training
 - Oklahoma PACT Team Site Visits
 - Onsite Training For Each team
 - Series of Modules in Core Areas (Strengths-Based Assessment/Person-Centered Planning; Motivational Interviewing for Engagement & Treatment of Co-Occurring Disorders, Housing Issues – Working with Landlords)
- WA-PACT Fidelity Scale



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Overview of Purpose

- Define best practices in Utilization Management of inpatient hospital beds
- Review process and practice of UM in State and Community Hospitals by RSNs and MHD.
- Focus on Medicaid and other publicly funded consumers served in Community Hospitals, voluntary and involuntary.
- All consumers served by the State Hospitals.
- Compare and analyze practice across the RSNs and State Hospitals
- Compare with practice in other states
- Develop options and recommendations for improvements



Project Methods and Activities

- Review history of Utilization Management via literature review, best practices and standards.
- Analysis and review of current practice via P&P review, data review and key informant interviews
- Comparison State Review PA,CO,AZ,NM
- Site visit at state hospitals with review of UM practices
- Consumer focus groups at State Hospitals
- Tribal government or representative interviews
- Other key stakeholder contacts, including NAMI, law enforcement, DSHS, community providers
- Community hospital survey
- Preliminary report due on May 31, 2007



Opportunities

- Highlight best practices in the appropriate management of hospital capacity.
- Ensure that limited inpatient resources are available for those who require this intensive setting.
- Spotlight therapeutic and resource barriers which prevent consumers from moving to a less intense level of care when they are ready.
- Assist the MHD in organizing and setting standards for ongoing management of state hospital and community inpatient resources



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Washington State System Transformation Initiative: Review of Involuntary Treatment Laws

May 15, 2007

Jenifer Urff, J.D. Advocates for Human Potential, Inc.

Overview of Project: Review of Involuntary Treatment Laws

- Review specific provisions in State involuntary treatment statutes
- Compare specific provisions with other states' approaches
- Identify strengths, challenges, and options for reform





Guiding Principles and Scope of Review

- MHD's desire to create a recovery-focused, resiliency-based system of care
- Specific focus on issues affecting State hospital utilization and civil commitment
- Relevant statutes
 - RCW 71.05 (Adults)
 - RCW 71.34 (Children)
 - RCW 10.77 (Forensic) as it applies to misdemeanor patients





Key Issues Identified for Analysis Include:

- Definition of "mental disorder"
- Definition of "gravely disabled"
- Age of consent / "parent-initiated treatment"
- Other topics discussed:
 - "Forensic conversion"
 - Concerns and implications for Tribal governments and members
 - Overview of other issues identified during review





Overview of Commitment Criteria

Civil Commitment Criteria:

- Mental disorder and
 - Likelihood of serious harm (substantial risk of physical harm to self, others, or property of others) or
 - Gravely disabled





Question 1

Involuntary treatment laws serve many important and sometimes competing policy objectives. *Please indicate the relative importance you would assign to each of the following policy objectives in connection with reforming Washington's involuntary treatment laws:*

 Ensuring public safety
 Protecting individual civil liberties
 Ensuring that individuals receive mental health treatment that they need
 Diverting individuals from the criminal justice system and homelessness
 Ensuring that parents can access needed mental health services for children and adolescents





Preliminary Findings

Broad range of perspectives regarding involuntary treatment and civil commitment

Make civil commitment more available as a mechanism to divert people who will otherwise be involved in the criminal justice system

Lower the threshold for commitment under the grave disability standard to make getting help easier

Narrow civil commitment laws to ensure that everyone who is civilly committed can benefit from hospitalization

Raise the threshold for commitment under the grave disability standard to promote civil rights and minimize the use of inpatient services





Question 2

Please indicate the degree to which you agree or disagree with the following statement:

The use of civil commitment in Washington State too often reflects a lack of sufficient appropriate, recovery-oriented community services, and developing these services would lead to an overall decline in the need for civil commitment.





Question 3

Please identify and rank the three factors that you think most affect the use of civil commitment in Washington State:

 Lack of adequate housing and other community residential options	
 Lack of employment options for people with mental illnesses	
 Lack of residential crisis alternatives in the community	
 Lack of specialized community services for special populations (e.g., people with dementia, TBI, developmental disabilities)	
 Subjective interpretations of the law by Designated Mental Health Professionals (DMHPs)	h
 Reaction by DMHPs and courts to high-profile incidents involving people with mental illnesses and violence	3
 Insufficient access to community mental health services that consumers really want	
 Insufficient access to services, such as PACT teams, that are specifically designed to serve people who experience the most serious symptoms of mental illness and who have not benefited from traditional approaches to treatment	
Actual language used in the ITA statute	25

Small Group Discussions

From the three factors just identified as having the most impact on the use of civil commitment in Washington State, please select <u>one</u> and discuss:

- What needs to be done to address this factor?
- How would that reform or improvement make a difference in the rates of civil commitment in Washington State?
- If reform of this factor is needed, what challenges to reform exist and how can they be overcome?

(20 minutes)





Preliminary Findings

- No uniform approach or "best practices" model
- No specific legal or medical definitions to rely on
- All states use different definitions to reflect structure of services systems and policy objectives
- Washington's definitions of "mental disorder" and "gravely disabled" are broader than many states and permit civil commitment in a broader range of circumstances





Preliminary Findings

Consensus of the STI Task Force:

- Most important statutory issue is definition of "mental disorder" because it results in the civil commitment of people who may not be best served in inpatient psychiatric settings
- Statute should not be narrowed unless adequate alternatives are available for people who would be affected





Preliminary Findings: Definition of "Mental Disorder"

RCW 71.05.020(22): "Mental disorder" means *any* organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions.

- Most states have narrower statutory definitions.
- Most states explicitly exclude people with certain diagnoses, such as developmental disabilities, mental retardation, TBI, or dementia from their definitions.





Preliminary Findings: Definition of "Mental Disorder"

Strengths:

- Breadth of definition provides flexibility
- People who meet civil commitment criteria receive services regardless of diagnosis or disorder

Challenges:

- Many people committed to inpatient psychiatric services cannot benefit from services in that setting
- Inpatient services become providers of last resort when needed services and supports for special populations are not available in the community

Options for reform:

- Narrowing the definition to include only certain mental illnesses or
- Excluding specific diagnoses or conditions





RCW 71.05.020(16): "Gravely disabled" means a person is:

- (A) In danger of **serious physical harm** resulting from a failure to provide for his or her essential human needs of health or safety; or
- (B) Manifests *severe deterioration in routine functioning* evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions *and* is not receiving *such care as is essential* for health or safety.





Question 4

Please indicate the extent to which you agree or disagree with the following statement:

In my opinion, the definition of "mental disorder" in Washington State is too broad, resulting in detention and civil commitment of people who are not best served in an inpatient psychiatric setting.

Strengths:

- Permits civil commitment of people who are experiencing a severe deterioration in functioning without requiring that they become dangerous to themselves or others
- Permits flexibility:

"A common theme here is that even though the grounds for commitment are present, a DMHP does not necessarily need to detain. However, if you shrink the available grounds for commitment, a DMHP will be unable to detain, even when the need to detain is great."





Challenges:

- About 62 percent of people detained in FY2006 were considered to be "gravely disabled" (although many may also have met other commitment criteria)
- Broader than most states, even those with similar "need for treatment" statutes
- Some consumers feel that they were detained principally because they were homeless, and that broad definition provides too much flexibility when there is no danger





Options for Reform:

- Repeal Part B of the statutory definition
- Modify Part B to:
 - Permit commitment only when the person is unable to make their own informed judgment about treatment
 - Permit commitment under part B only if the person's deterioration is likely to result in their meeting other commitment criteria
 - Permit commitment only if the person's deterioration is likely to result in the person requiring involuntary hospitalization based on prior experience





Question 5

Please indicate the extent to which you agree or disagree with the following statement:

In my opinion, the definition of "gravely disabled" mental disorder" in Washington State is too broad, resulting in the over-use of detention, civil commitment, and inpatient services.





Question 6

Please indicate which of the following statements best represents your own view:

I would support narrowing criteria for civil commitment, but only if needed community services and resources were in place first.
 I support narrowing criteria for civil commitment as a first step, with the belief that statutory change will motivate the state to create a more effective community-based, recovery-oriented service delivery system.
 I would not support narrowing criteria for civil commitment

under any circumstances.

Preliminary Findings: Age of Consent and Parent-Initiated Treatment

RCW 71.34.600 – 71.34.660:

- A minor 13 years or older may receive outpatient mental health services or admit themselves to an evaluation and treatment facility for inpatient treatment without parental consent.
- A parent may take a minor child to an appropriately licensed facility and request examination and admission as an inpatient.
- Minors will not have a cause of action against the facility for admitting the minor in good faith based solely on their not consenting to treatment if their parent did consent.





Preliminary Findings: Age of Consent and Parent-Initiated Treatment

- Research supports legislative finding that Parent-Initiated Treatment is not used.
- Possible Explanations:
 - Parents are unaware of this option
 - Lack of clarity regarding due process procedures for minors who do not consent
 - Concern regarding independent reviews of provider admission decisions and/or other reimbursement issues





Question 7

Please indicate which of the following statements <u>best</u> represents your own view:

- Teenagers (ages 13-17) should be able to make their own decisions about mental health care and should be treated against their will only if they meet the same civil commitment criteria as adults.
- Teenagers should be able to seek and receive both inpatient and outpatient mental health services without their parents' knowledge or permission, but they should not be able to refuse treatment that their parents and treatment providers feel they need.
- Teenagers are not yet mature enough to make decisions about their own mental health care, and parents, in collaboration with clinicians and other treatment providers, should be the final decision-makers regarding their treatment.





Other Important Issues

- Involuntary Medication
 - "Second signature" issue: Permit involuntary medication of individuals receiving short-term treatment up to 30 days under civil commitment if two concurring medical opinions
 - Very important to consumers and legal advocates;
 others agree that law may present constitutional issue
 - Possible reforms range from never permitting involuntary medications without advance directives to requiring hearings in non-emergencies





Other Important Issues

- Definition of Likelihood of Serious Harm
 - Permits civil commitment where "physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others."
- Advance Directives
 - RCW 71.32 provides for mental health advance directives, but says they won't apply when a person is civilly committed
- Training for DMHPs
- Conversion from involuntary to voluntary status





Question 8

Please identify and rank the three issues that you believe should be priorities for follow-up research and/or initiatives of the Mental Health Division:

 Advance directives
 Involuntary medications
 Mandatory, uniform training for DMHPs
 Facilitating conversion from involuntary to voluntary status
 Commitment permitted for "harm to property to others"
Parent-initiated treatment





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Washington State System Transformation Initiative

Mental Health Benefits Design Project Recommendations: Stakeholder Review, Discussion, and Input



Andrew Keller, PhD May 15, 2007



Areas for Discussion Today

- ➤ Question #1: Identify <u>your</u> primary focus for today:
 - Children and families
 - ✓ Adults
 - ✓ Older adults
- Review and prioritize recommendations regarding Access to Care for Medicaid
- Review and prioritize recommendations regarding Best Practices (evidence-based practices, promising practices, and culturally-relevant services)



End of the Meeting: Hard Choices

- Many of these recommendations will require additional resources; we need help prioritizing which to recommend doing first:
 - Expanding access to all RSN services
 - Creating a system infrastructure to promote Best Practices broadly
 - Deciding which specific Best Practices to promote
- > As a group we will work through the pros and cons of each recommendation
- > We will come back together at the end to prioritize the entire set

May 15, 2007



Findings on Medicaid Access to Care Standards (ACS)

- Currently: To receive Medicaid services through an RSN, a person must:
 - ✓ Have a covered diagnosis (there are two lists List A and List B)
 - ✓ If over age 5, have a functional impairment measured by a standard functioning protocol (GAF for adults, CGAS for children/adolescents)
 - ✓ This is based on a good intention to focus the public mental health system on those most in need, letting those with less severe needs access outpatient services through Healthy Options and the fee-for-service system
- In our interviews, Medicaid ACS are generally seen by stakeholders to create bureaucratic burden with little benefit and overemphasis on front-end limitations to outpatient care; this leads to two problems:
 - ✓ For clinical care, a barrier to early intervention for high-risk populations
 - ✓ For coordination of care and effective utilization management, it dilutes emphasis on managing higher need cases (long-term case management, day support, residential services)



Opportunities to Refocus ACS Implementation for Medicaid

- More flexibility to individualize care up front appears to be allowable <u>now</u>, under current waiver
 - ✓ ACS: "Access . . . [and] The full scope of available treatment modalities may be provided . . . based on clinical assessment, medical necessity and individual need."
- ➤ This is not changing ACS, but rather refining statewide standards to guide implementation; options include:
 - ✓ Raise the functional cut-off to serve more persons across the board
 - ✓ Develop criteria to support broader outreach to high-risk groups
 - ✓ Develop comprehensive statewide medical necessity criteria to better manage care





Reasons For and Against Making a Change

- Stakeholders have identified many reasons for this change:
 - ✓ Lack of access for high-risk populations in need of outreach
 - ✓ Broader lack of access for people with mental health needs, but less functional impairment
 - ✓ Too much focus on front-end restrictions, rather than high-need cases
 - ✓ Bureaucratic burden on RSNs & providers of complex requirements
- Concerns about making a change have also been noted:
 - ✓ Concerns that unmet demand will create major additional costs
 - ✓ Overlap between the roles of RSNs versus FFS/Healthy Options
 - ✓ Concern about diluting the ability of RSNs to meet high need cases if their mission is expanded to include lower need cases







> What reasons do you think support making a change?

What reasons do you think support not making a change?

Take 10 minutes to discuss these issues at each table, then reconvene



What Concerns do You Have about Medicaid ACS

you may choose more than one or none):
 Concern #1: Currently, high-risk people in need do not receive care because of ACS functional requirements
 Concern #2: Currently, many people with less intensive mental health needs do not receive care because of ACS functional requirements
 Concern #3: Currently, RSNs and providers spend too much time and resources complying with paperwork for ACS requirements
 Concern #4: Currently, RSNs and providers spend too little time and resources trying to manage the care of people with complicated needs
 Other Concerns: (Please list them on the form provided in your packet)

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What Concerns do You Have about Changing Medicaid ACS

	Do you share any of the following concerns about <u>changes</u> to the ACS (you may choose more than one or none):
	Concern #1: It will cost more money than the system currently has to provide more outreach to high-risk groups
	Concern #2: It will cost too much additional money to provide mental health care through RSNs to people with a covered diagnosis, but less functional impairment
	Concern #3: Expanding access to RSN services will create unwanted duplication with Healthy Options and FFS services
	Concern #4: Expanding access to RSN services will dilute the ability of RSNs to serve those most in need
	Other Concerns: (Please list them on the form provided in your packet)
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TRIWEST GROUP



Vote on Proposed Change in Current Implementation of the ACS

Question #4: Which of the following statements best represents your view about potential changes in ACS implementation? (please choose only one)

 Option #1: Make no changes to the current Medicaid ACS
 Option #2: Change the criteria so that RSNs still serve only those most in need, but they are also able to outreach high-need cases
 Option #3: Change the requirements so that RSNs can serve all people with covered mental health diagnoses
 No opinion – Not enough information provided to rate

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Findings on Evidence-Based Practices

- Analysis of Washington's State Medicaid Plan
 - ✓ Carried out comparisons of WA to AZ, CO, NM and PA
 - ✓ WA's State Plan is very flexible; able to promote wide range of practices.
 - ✓ CMS is increasingly strict, so should only amend Plan if major need.
 - ✓ Currently, RSNs choose Best Practices and develop within current funds
- Major limitations applying EBPs / Promising Practices in "real world"
 - ✓ For any, **efficacy** in studies does not equal **effectiveness** in practice
 - ✓ Research lacking in typical practice settings with vacancies, turnover, differential staff training, co morbid conditions
 - ✓ Very few major EBP/PPs directly incorporate cultural considerations
- > It does not work to simply mandate Best Practices across the board
 - ✓ Only seems to work to systematically promote a handful of practices
 - ✓ Infrastructure development also necessary (training, monitoring, rates)
- "Centers of Excellence" generally tied to successful statewide promotion of specific services (ACT, Peer Support)



Components of Evidence-Based Culture

- Need for a broad-based culture committed to learning, tailoring efforts to communities and individuals, and changing systems in response
- > Key components include:
 - ✓ Involves all levels of the system state, Tribes, region, managers, clinicians
 - ✓ Begins with a thorough understanding of the current treatment system.
 - ✓ Systematic review of many types of available evidence
 - ✓ Support of sufficient reimbursement for Best Practice implementation, including reimbursement for needed training and clinical supervision
 - ✓ Data collection and reporting mechanisms in place to document results
 - ✓ Bi-directional communication between researchers and clinicians
 - ✓ Appropriate balance between fidelity and adaptation
 - ✓ Uses outcome data to drive systems change.







- What benefits do you see in the use of best practices?
- What concerns do you have about the use of best practices?
- What do you think constitutes a culture that promotes best practices?
- Take 10 minutes to discuss these issues at each table, then reconvene





Vote on How Best to Promote Best Practices

Question #5: Which of the following statements best represents your view about how to promote Best Practices? (please choose only one)

 Option #1: Make no changes: Continue to let RSNs choose Best Practices and develop them within current funding levels
 Option #2: Prioritize three to five Best Practices for statewide implementation with new funds (adjusted rates, legislative appropriations)
Option #3: Prioritize three to five Best Practices for statewide implementation with new funds (adjusted rates, legislative appropriations) and "Centers of Excellence"
 Option #4: Do not promote Best Practices; focus on broader access
 No opinion – Not enough information provided to rate



Criteria for Prioritizing Best Practices for Statewide Promotion

- 41 different best practices identified
- > Primary goals used to prioritize practices for statewide promotion:
 - ✓ Biggest clinical impact (with emphasis on appropriate inpatient utilization)
 - Promotion of recovery and resilience
 - ✓ Promotion of culturally relevant practices and cultural competence
 - ✓ Promotion of consumer/family-driven care
 - ✓ Distribution across age groups
- Additional goals considered:
 - ✓ Widest and most immediate possible impact
 - ✓ Prioritize five, but promote as many best practices as possible
 - ✓ Potential cost offsets





Establishing Statewide Priorities for Best Practices

- > Through our study, we have identified five Best Practices for statewide promotion, including rate setting and "Center of Excellence" strategies:
 - ✓ Consumer and Family-Run Services
 - ✓ Integrated Dual Disorder Treatment (IDDT)
 - ✓ Collaborative Care in Primary Care Settings
 - ✓ Multidimensional Treatment Foster Care (MTFC)
 - ✓ Wraparound Service Coordination
- Questions to consider for table discussion
 - ✓ Are there other Best Practices on the two lists provided that are more important to include in the "top five"?
 - ✓ Are there other Best Practices <u>not on the lists</u> that are more important?
- > Take 10 minutes to discuss these issues at each table, then reconvene



Priority Best Practice #1: Consumer / Family-Run Services

- Washington's Peer Support modality is very broad and superior to those of most of the comparison states
- However, requirement that the service must be provided by a CMHA complicates the peer-nature of service delivery by requiring that it take place in a professional setting
- The 1915(b) waiver could allow delivery of this service in other defined consumer and family-run settings similar to those allowed under Arizona community support agency provider type
- While this adds to the administrative burden of provider oversight by the State and RSNs, it also allows delivery of these peer-run services by less costly providers
- Could also facilitate interventions such as drop-in centers, family psychoeducation, and other consumer / family supports
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Vote on Proposed Endorsement of Consumer / Family-Run Services

Question #6: Do you agree or disagree with the following statement: **Services directly provided by consumer and family-run organizations** should be a top priority for statewide promotion by the MHD.

 Do not Know
 Strongly Disagree
 Disagree
 Agree
 Strongly Agree





Priority Best Practice #2: Integrated Dual Disorder Treatment

- IDDT provides mental health and substance abuse services through one practitioner or treatment team and co-locates all services in a single agency (or team)
- IDDT encompasses 14 components, each of which is evidence-based, including:
 - 1. Screening and assessments that emphasize "no wrong door"
 - 2. Stage-wise treatment that recognizes that different services are helpful at different stages of the recovery process
 - 3. Motivational interviewing and treatment
- > IDDT is effective at engaging people with both diagnoses in outpatient services, maintaining continuity of care, reducing hospitalization, decreasing substance abuse, and improving social functioning

Vote on Proposed Endorsement of Integrated Dual Disorder Treatment

Question #7: Do you agree or disagree with the following statement: **Integrated Dual Disorder Treatment** should be a top priority for statewide promotion by the MHD.

 Do not know
 Strongly Disagree
 Disagree
 Agree
Strongly Agree

Priority Best Practice #3: Collaborative Care in Primary Settings

- Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services
- > Two key principles form the basis of the Collaborative Care model:
 - Mental health case managers and professionals are integrated into primary care settings
 - Psychiatric and licensed clinical consultation and supervision is available to provide additional mental health expertise where needed
- Key components include screening, consumer education and selfmanagement support, mental health specialty referrals as needed, and linkages with other community services

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Collaborative Care in Primary Settings for Older Adults

- Multiple studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders, depression in adults, and depression in older adults
- IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression) is a multi-state Collaborative Care program with study sites in five states, including Washington
- > Focus on older adults found:
 - ✓ Higher satisfaction with depression treatment
 - ✓ Reduced prevalence and severity of symptoms
 - ✓ Complete remission as compared to usual primary care



Vote on Proposed Endorsement of Collaborative Care in Primary Settings

Question #8: Do you agree or disagree with the following statement: Collaborative Care in Primary Care Settings should be a top priority for statewide promotion by the MHD.

 Do not know
 Strongly Disagree
 Disagree
 Agree
Strongly Agree



- MTFC is a type of therapeutic foster care provided to children and youth living with foster parents or for families who require an intensive period of treatment before reunification
- MTFC is a well established EBP with research support for its efficacy with Caucasian, African American, American Indian youth and families
- As an alternative to residential, institutional, or group care for youth with significant mental health problems, MTFC provides treatment in a foster care home with trained foster parents
- Recent study of residential inpatient capacity recommended development of MTFC to expand safe settings for children and youth to take pressure off use of currently limited residential capacity

Vote on Proposed Endorsement of Multidimensional Treatment Foster Care

Question #9: Do you agree or disagree with the following statement: **Multidimensional Treatment Foster Care** should be a top priority for statewide promotion by the MHD.

 Do not know
 Strongly Disagree
 Disagree
 Agree
 Strongly Agree



Priority Best Practice #5: Wraparound Service Coordination

- Wraparound is a service delivery process to coordinate a set of individually tailored services to the child and family using a teambased planning process.
- The process focuses on strengths and includes a balance between formal services and informal community and family supports.
- Wraparound is not a treatment in itself, but is instead a coordinating approach to ensure the child and family receives the most appropriate set of services possible.
- The Wraparound research base is only emerging and more extensive implementation and empirical research is needed. The National Wraparound Initiative has defined ten core Wraparound Principles.



10 Core Wraparound Principles

- 1. Family voice and choice
- 2. Team-based process
- 3. Natural supports
- 4. Collaboration
- 5. Community-based support
- 6. Cultural competence
- 7. Individualized services and supports
- 8. Strengths-based services and supports
- 9. Persistence
- 10. Outcome-based



Vote on Proposed Endorsement of Wraparound Service Coordination

Question #10: Do you agree or disagree with the following statement: Wraparound Service Coordination should be a top priority for statewide promotion by the MHD.

 Do not know
 Strongly Disagree
 Disagree
 Agree
 Strongly Agree



Balancing Priorities with Limited Resources

- Over 40 practices were identified for possible analysis and prioritization through this study
- Successful states have focused on a handful of statewide priorities at a time
- We have offered two broad recommendations:
 - Broaden outreach and early identification under ACS
 - Promote a broad-based "evidence-based culture"
- We have recommended prioritizing five best practices statewide
- There are other important practices we have not prioritized as initial focuses, but we will offer recommendations on how to better support (for example, supported employment)
- Final questions ask you to help guide policy-makers





Vote on Priorities Among Recommendations Discussed Today

Question #11: What should the MHD prioritize given limited resources? Please choose your top three priorities from the following <u>eight</u> potential system changes.

 Broader ACS criteria to allow RSNs to serve more people across the board
Support for a broad-based "evidence-based culture"
 Statewide support to implement Consumer/Family Run Community Service Agencies (CSAs)
 Statewide support to implement Integrated Dual Disorder Treatment (IDDT)
Statewide support to implement Collaborative Care in Primary Care Settings
 Statewide support to implement Multidimensional Treatment Foster Care (MTFC
Statewide support to implement Wraparound Service Coordination
 Statewide support to implement a different practice (Please specify which one on the voting card provided)



Contacting TriWest with Additional Input

If you have additional input or concerns you would like to share, please contact **Andy Keller** using the contact information below:

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Mental Health Housing Plan

Presentation for May 15th STI Public Forum

Prepared by Common Ground

Mental Health Housing Plan

- Preliminary Housing Plan: draft available now
- Action Plan: in development
- Technical Assistance: available now
- Final MH Housing Plan: available this summer



Initial Findings

- All RSNs need a range of housing options
 - Licensed residential facilities
 - Community based housing
 - Crisis respite beds

 Permanent Supportive Housing (PSH) most appropriate for most MH consumers



Initial Findings, cont.

- All RSNs need a lot more PSH
 - Estimated need for up to additional 5000 units in WA
- RSNs should replace some large licensed congregate care facilities with smaller specialized facilities or PSH
- All RSNs need short-term crisis respite beds



PSH for Mental Health Consumers

 New units developed specifically for people with mental illness

OR

- Existing housing units
 - Master lease by MH provider with subleases to MH consumers or
 - □ Individual leases directly with MH consumers



PSH for Mental Health Consumers, cont.

- Requires rent subsidy tied to MH consumer or operating subsidy tied to the unit
- For many existing units, landlord incentives are necessary to overcome stigma and/or increased costs
 - e.g., extra subsidy for wear and tear on units; access to 24/7 crisis response from MH provider



PSH for Mental Health Consumers, cont.

- Housing linked to supporting services delivered in home and community settings
- Range of supportive housing from structured programs with firm rules to low barrier/Housing First with few requirements



PSH for Mental Health Consumers, cont.

- Case manager caseloads ranging from 1:8-1:20 depending on needs of consumers
- Estimated annual service costs:
 - \$3000-\$11,000 (average \$7500) for individuals
 - □ \$5000 -\$14,000 (average \$9000) for families



Draft Action Plan Goals 2007-2010

- 760 PSH units
 - □ 500 newly developed units from projects already in predevelopment
 - □ 260 units from existing housing stock
- 80% of units in RSNs with urban centers (King, Pierce, North Sound, Spokane)



Draft Action Plan Goals 2007-2010, cont.

- Of the 760 units:
 - □ 500 for single adults
 - □ 160 for families
 - □ 100 for seniors
- Up to 60% of units for PACT consumers
- Up to 70% of units for homeless consumers



2007-2010 Draft Financing Assumptions

- Existing capital sources sufficient to meet target
- 2007 levels of operating/rent subsidy sufficient IF greater proportion of subsidy goes to housing for MH consumers



2007-2010 Draft Financing Assumptions

- Additional service \$ required for consumers not receiving PACT services
- Additional \$ for technical assistance
- Additional \$ for landlord incentives
- Additional \$, if necessary, for crisis respite beds



Draft Strategies for 2007-2010

Creating many of units in larger
 RSNs and RSNs with PACT teams

 Using experienced MH providers and increasing linkages with housing providers in their communities



Draft Strategies, cont.

 Increasing coordination among the public agencies financing housing and services

 Providing technical assistance for RSN and provider capacity building



Draft Action Plan Goals 2010-2015

- 1600 additional units
- Broader spread across all RSNS
- Increase in % of units for seniors and for consumers who are not homeless
- Significant increases in existing housing and service resources and/or new resources required



Question 1. There are existing housing units available in your community that are suitable to meet the needs of people with mental illness.

- 1. Strongly Disagree
- 2. ...
- 3. ...
- 4. ...
- 5. Strongly Agree



Question 2. With adequate rent subsidies available, the existing housing units would be sufficient in my community.

- 1. Strongly Disagree
- 2. ...
- 3. ...
- 4. ...
- 5. Strongly Agree



Question 3. In addition to affordability, rank the top three barriers for landlords renting to individuals with mental illness:

- 1. Stigma
- 2. Lack of 24/7 access to problem solving mental health staff
- 3. Criminal histories
- 4. Arson records
- 5. Poor credit
- 6. Excess wear and tear
- 7. Consumer turnover rates



Question 4. If housing and rent subsidies were available, do mental health providers have enough resources in their RSN contracts to provide the supportive services called for in the PSH model? (average \$7500/year)

- 1. Yes, for the PACT clients and no for the rest
- 2. Yes for PACT clients and a limited number of others
- 3. Yes for PACT and a significant number of others
- 4. Not enough information



Question 5. RSNs should include "low barrier, housing first" programs with few requirements (e.g., being able to drink in your apartment, housing not contingent on treatment compliance).

- 1. Strongly Disagree
- 2. ...
- 3. ...
- 4. ...
- 5. Strongly Agree



Question 6. There are adequate numbers of affordable "low barrier, housing first" programs and beds for mental health consumers in my community.

1. Strongly Disagree

2. ...

3. ...

4. ...

5. Strongly Agree



Question 7. Rank the top three incentives that might encourage private landlords to rent to people with mental illness:

- Extra operating subsidy for wear and tear on units
- 2. Protection from liability for renting to people with past felony convictions for drug crimes or crimes against persons
- Guaranteed 24/7 emergency response for tenant crisis
- Active and responsive case management support for tenants
- Guaranteed stream of rent payments through master leasing



Question 8. How comfortable are you with the goals, 760/5000, that meet 15% of the need by 2010 and 1600/5000 that meet another 30% = less than half of total need by 2015?

- 1. Too low / we will never meet the need at this rate
- 2. Reasonable / balance of what is ideal and what is achievable given all priorities
- 3. Too high / not realistic to achieve



Question 9. To be successful, the MH Housing Action Plan requires new strategies and/or changes from current practice. Rank your top three choices of strategies for achieving plan goals:

- 1. Ongoing technical assistance for RSNs & providers
- Closer coordination of policy and funding decisions among state agencies
- 3. Greater collaboration with law enforcement, jails and ERs
- 4. Greater collaboration with housing authorities and housing providers
- 5. Greater responsiveness to landlords
- 6. Short term crisis options while holding housing unit
- 7. Greater consumer participation in securing housing for themselves and others



Question 10. Where should permanent supportive housing rank among RSN priorities for unmet needs?

- 1. Low Priority
- 2. Medium Priority
- 3. High Priority
- 4. Top Priority



Table Discussion

- 1. What roles can consumers and family members play in securing and maintaining permanent supportive housing for themselves or others?
- 2. What can the system do to support consumers in these roles?
- 3. Do you have any other comments or suggestions about housing for people with mental illness that the Consultant should know about?



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Wrap Up

For further information on STI:

http://www1.dshs.wa.gov/Mentalhealth/STI.shtml

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